Opening Pandora's Box: Delivering Trauma-informed Treatment in the Medical Home

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Presentation Outline

- To briefly introduce workshop participants to the ACEs Alberta Research Program.
- To describe a collaborative model of care in which physicians, patients and mental health consultants work together to address ACEs and other mental health concerns in the medical home.
- To discuss the need for trauma-informed care practices and evidenced based treatment in the medical home, potential barriers to implementation and circumstances that fit "just right."
- To outline an evidenced based proposal for treating adults with high ACE scores within the medical home.

ACEs Alberta Research Program-Briefly!

The ACEs –A program is investigating the relationship between adverse childhood experiences (ACEs) and physical and mental health outcomes in later life among Albertan adults.

This research represents an extension of the landmark ACE study originally completed in San Diego, California (Felitti, et al., 1998).

Purpose: to develop an effective intervention which can be offered in primary care settings to Albertan adults, who have endured traumatic childhood experiences, thus helping to lower subsequent health care costs and improve patient care for these individuals.

Design: This program of research will take place over four phases. Phase 1 is complete, phase 2 is underway and phase 3 will be discussed in this presentation.

ACEs-A Research Team

Influence of the Recovery From Addiction Symposium(2011-2014)

Support provided by the Norlien and Max Bell Foundations

The Research Team:

- Alberta Health Services
  -Shared Mental Health Care Program
  -Chief Addiction and Mental Health Officer
- University of Calgary
- PCN and Physician Involvement
- ACEs Research Coordinator
- Advisory Group: Individuals with lived experience of ACEs
- Expert Consultation: Dr. Robert Anda, Dr. John Briere, Dr. Marylene Cloitre

Shared Mental Health Care Program

Shared Mental Health Care (SMHC) is a consultation program that partners family physicians with mental health consultants (e.g., psychiatrists, nurses, social workers, psychologists)to enhance mental health services delivered by family physicians at the primary care level.

Two services are provided under this mandate:

Shared Mental Health Care Service (SMHC)

Behavioral Health Consultation Service (BHC)

SMHC and BHC are involved with approximately 725 physicians in 170 clinics

Approximately 13,000 patients were seen by both services in 2014

The Role of Shared Care in Promoting Trauma Informed Practices in Primary Care

- Joint sessions that leverage the existing relationship between the physician and their patient.
- The patient can access complete physical and mental health care in one location.
- Coaching, education, modelling of skills and invitation to open Pandora's Box.
- Support to physicians which spans their entire practice (not only with patients seen) and transferability of skills learned.

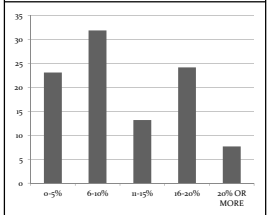
Why Ask About ACEs?

Mary's Story: ACEs in Primary Care

- 60 year old woman who presented at a walk-in clinic with high blood pressure and anxiety.
- Continuous involvement over a 12 year period revealed a history of childhood trauma and multiple chronic health conditions; as well as resilience and protective factors.
- Collaboration regarding effective treatment of this patient was facilitated through involvement in the Shared Mental Health Care program.

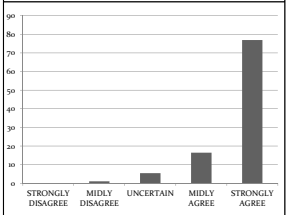
ACEs Alberta Conference 2015: Physician Needs Assessment

What percentage of patients do you see in a given clinical day who present with a history of childhood trauma (i.e., significant abuse, neglect, and/or family dysfunction)?



- Percentage of patients presenting with history of childhood trauma (in a given clinical day).

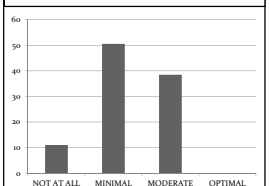
To what extent do you agree with the following statement? : "Childhood experiences of toxic stress are a leading determinant of both physical and mental health in adulthood."



- Percentage of clinicians agreeing with statement : "Childhood experiences of toxic stress are a leading determinant of both physical and mental health in adulthood."

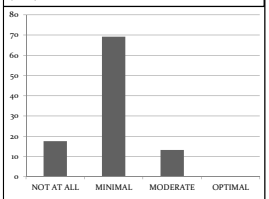
Sequelae of ACEs

To what extent do you consider yourself able to clearly articulate the physiological and emotional sequelae of adverse childhood experiences (ACEs)?



- Percentage of clinicians that consider themselves able to clearly articulate the physiological and emotional sequel ae of adverse childhood experiences (ACEs).

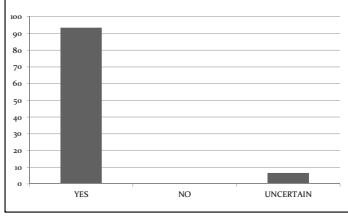
To what extent do you consider yourself able to clearly articulate an evidence-based treatment plan for adults who have been exposed to adverse childhood experiences (ACEs)?



- Percentage of clinicians that consider themselves able to clearly articulate an evidence-based treatment plan for adults who have been exposed to adverse childhood experiences (ACEs).

Will Patients Benefit from a Greater Understanding of ACEs? Physician Perspectives

Do you believe your patients would benefit if you had a deeper understanding of the long term effects of childhood trauma, including how those effects can be moderated in adults?



- Percentage of clinicians who agree that their patients would benefit if they had a deeper understanding of the long term effects of childhood trauma, including how those effects can be moderated in adults?

What I have learned: Gaps in Physician Training

- Physicians feel there are gaps in training!
- Is childhood trauma underestimated because we do not currently screen for it?
- Physicians believe more knowledge and training would enhance patient care!
- Can this research impact change in training health care professionals in the future?

Screening for ACEs in Primary Care

- Incorporated into practice as routine screening similar to how screening is conducted for use of tobacco, ETOH and other health concerns.
- Screening procedures would be brief in nature and potentially completed in the waiting room, prior to the medical visit.
- Positive screening would result in an invitation for referral to the SC or BHC in the clinic for further assessment and treatment recommendations.

Required Changes in the Medical Home to Incorporate Routine Screening for ACEs

- Health care provider and patient education about the value of screening practices.
- The landmark Adverse Childhood Experiences (ACE) study in San Diego, California, revealed several remarkable results following screening, including a pronounced relationship between the experience of early childhood adversity and adult health, as well as a dramatic 35% reduction in health utilization, once early experiences were identified and reflected upon.
- If these results can be replicated and extended they have significant implications for health care in Alberta.

The Myths and Fears of Pandora's Box

- The belief that asking patients questions about their ACEs in a supportive health/research environment is potentially harmful is not substantiated in the literature.
- In many research studies (including our own), patients reported few (mild) negative effects, and generally were appreciative that they had been asked about these experiences.
- Some indicated that it provided initiative to pursue counselling and others felt strongly that their contributions to the research could help others.

When Pandora's Box is Open

- Physicians are fearful that they may have insufficient time or skill to manage ACEs in primary care settings.
- Issues do not need to resolved in one visit and many options are possible.
- Collaboration is key!

How Mary's Care has been Enhanced by Knowledge of ACEs

- Thorough understanding of ACEs facilitates more comprehensive (biopsychosocial) treatment.
- Sensitivity to the impact of ACEs on overall health increases compassion and effectiveness with other patients who have experienced ACEs (and the literature indicates that most of us have experienced ACEs).
- Development of an intervention creates hope that future health issues may be attenuated.

Next Phase: Designing the ACEs Treatment

Our Goal

- To create an affordable, effective, primary care-based treatment option for people with high ACE scores to help offset the mental and physical health problems that they are more at risk to encounter in the future.

Our Challenges

- What should the treatment include?
- How to convince people to try the treatment?
- How many people should receive the treatment?
- How to find people to deliver the treatment?
- How to tell if it made any difference?
- How to convince physicians to get on board?
- Present or past focus?
- Individual vs group vs online format?

Our Process

- Formed a treatment development working group
  - Psychologists, social workers, advisory group member, family physician, neuroscientist
- Literature review of effective forms of treatment for ACE's
  - CBT, mindfulness, expressive writing
- Other materials/models clinicians drew from to inform trauma-based model for PC
  - Judith Herman's model, CBT trauma manuals, Cloitre's STAIR model, relationship factors/role of compassion
- Each participant proposed a model
  - Collaborative debate to create the proposed model

Our Process

- Feedback on proposed model
  - Trauma experts
  - Advisory Group
  - BHC experts
- Incorporating the feedback
- Ongoing consultation
- Open trial
- RCT

Treating Complex Trauma

- Prolonged exposure to repeated or multiple traumatic events from which escape is not possible due to environmental, social, psychological, maturational forces
  - Typically of an interpersonal nature
    - Domestic violence
    - Physical abuse
    - Sexual abuse
    - Chronic neglect
    - Prisoner of war

Treatment Guidelines for ACE Patients

- Rehabilitation/habilitation of life skills
- Emotion regulation and interpersonal skills as key
- Strengthen mastery in health
- Increase social support network
- Address and reappraise past trauma

(Cloitre, 2015)

Benefits of Integrated Care for the Patient with ACEs

- Sends message: body and mind are related
- Streamlines referral process
- More likely to get "good" care (providers and services are "vetted)
- Importance of compassion (non-pathologizing language)

Module 1: STAIR (Cloitre)

SKILLS TRAINING IN AFFECT AND INTERPERSONAL REGULATION

THE RESOURCE OF HOPE
- Session 1: Rationale, Motivation and Goals

THE RESOURCE OF FEELINGS
- Session 2: Emotional Awareness and the Power of Naming
- Session 3a: Emotion Regulation - Body
- Session 3b: Emotion Regulation - Mind
- Session 3c: Emotion Regulation - Behavior
- Session 4: Distress Tolerance

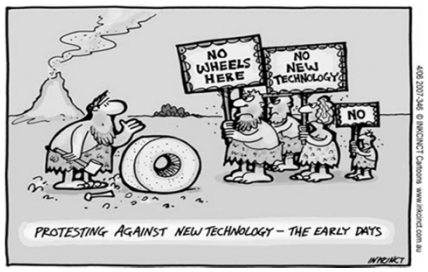
THE RESOURCE OF CONNECTION
- Session 5.: Understanding Relationship patterns
- Session 6: Changing Relationship Patterns
- Session 7: Agency in Relationships
- Session 8: Flexibility in Relationships

Importance of good relationships

- Research indicates that good parental care can counter the effects of ACEs and produce **RESILIENCE** to toxic stress later in life.

(Hackman et al 2010 from Hill, 2015)

Online treatment options?



The 'Basics' of online therapy

- Typically structured self-help materials presented in a systematic step-by-step and accessible way
- Include text, video, audio, graphics, occasionally cartoon animations
- Broken into modules or lessons
- Often include homework exercises
- May include downloadable forms and audio content

(Jones 2015)

Research on online PTSD/trauma Programs

Klein et al. (2010)
- Open trial; 22 participants
- 10-week, 10 module I-CBT program
- 27.4% attrition rate
- Significant change in PTSD symptoms, maintained at 3-month follow-up
- Moderate satisfaction, high therapeutic alliance ratings
- Therapists spent 3 hours, 14 minutes on average/ participant

Spence et al. (2011)
- RCT; 42 participants
- Seven lessons over 8 weeks
- Weekly homework assignment; forum discussions
- Therapist emails, automatic reminders
- Additional written resources
- 78% completed program in 8 weeks
- High comprehension and compliance with homework practice
- I-CBT group had significantly lower PCL-C scores at post-treatment
- Therapists spent 103.91 mins on average/participant

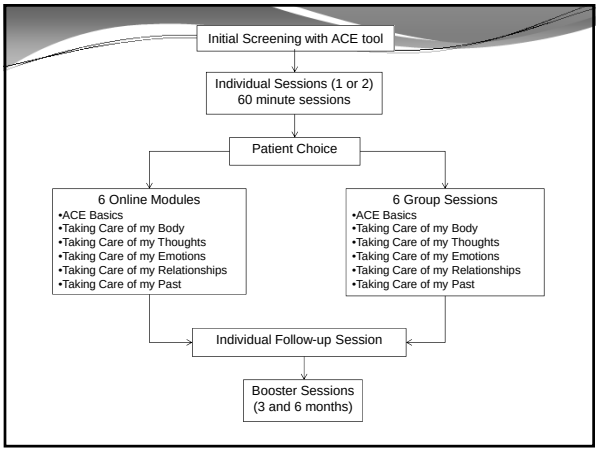
(Jones 2015)

Internet-CBT in primary care

- Effectiveness of ICBT in routine clinical practice (Ruwaard et al., 2012)
  - 1500 patients with depression, panic, PTSD, or burnout
  - Treatment adherence was 71%
  - Study attrition was 21% at post-test, 33% at 6-week FU and 65% at 1-year FU
  - Large short-term reductions observed on all primary outcome measures
- Mixed anxiety and depression RCT and effectiveness trial in primary care (Newby et al., 2013)
  - RCT showed I-CBT program (n = 46) more effective than WLC group (n = 53); high adherence (89%)
  - Effectiveness trial (n = 136) showed large effects but lower adherence (41%); 30% of non-completers experienced benefit

(Jones, 2015)

How to bring it all together...



Screening

- Physicians have patients complete the ACEs questionnaire as part of their physical exam. Discuss the importance of the ACE score, and invite patients beyond the cut-off to have at least a session with the clinician, and to talk about possibly joining the study.

Phase 1 – Connecting patient to treatment

- **Individual session with the SC or BHC clinician**
  - **1-2/60 minutes**
- **Inclusion Criteria:** 18+yrs, positive ACE score, "stable enough" for intervention (defined below)
- **Exclusion Criteria:** acute symptoms of psychosis/dissociation, acute suicidality, need for immediate substance abuse treatment, basic language skill (able to communicate in English and minimum grade 5 written language ability), current involvement in treatment elsewhere

Phase 1-connecting the patient

- Introduce idea of developing a **self-care plan**
- Emphasis on building **rapport/connection/safety**
- **Psycho-education** about ACES and basic structure and themes of the group/module treatment
- **Continuum** of treatment beginning with building a relationship and skills development followed by checking the extent to which the patient wants to engage in trauma processing

Phase 2 – Skills-based group or online module

- All sessions to include skills-focus, experiential component and homework
- CBT as general framework
- Promote resiliency, strength-based approach and introduce new learning
- Honour patient choice and build on existing skills while addressing skills deficits common w/ ACEs
- Co-facilitation in groups/therapist-assisted in online
- Daytime and evening groups
- Minimum 8 - maximum 15 participants

Session #1 – Basic info about ACEs, Brain Development, Health and Coping

- Pre-intervention measures
- Develop group norms/comfort/safety
- Invite discussion about the impact of trauma (use of Norlien materials) and the role of resiliency
- Discuss how ACEs can impact intrapersonal and interpersonal life
- Connection to values ("How can you live the life you want?")
- Reinforce the development of a self-care plan ("Back then, I wasn't taken care of the way I should have been – now I need to take good care of myself.")

Session #2 – Taking care of my body

- The role of adrenalin and cortisol in ACEs
- Diaphragmatic breathing
- Relaxation training
- Role of diet/activity/sleep
- Role of avoidance behaviours
  - substance abuse
  - behavioural addictions
    - "How can you live the life you want?"

Session #3 – Taking care of my thoughts

- Review basic ABC model
- Discuss Cognitive Processing construct of "stuck points" or "what are my triggers and what can I do to manage them"
- Review common thinking errors
- Demonstrate use of 4 column thought record
- Ideas for managing intrusive trauma thoughts

Session #4 – Taking care of my emotions

- Explain the role of managing emotions as key to building additional resiliency
- Grounding and containment strategies
- DBT skills
- "Emotion surfing"
- Mindfulness approach

Session #5 – Taking care of my relationships

- Invite significant others to attend if desired
- Communication skills
- Managing conflict and setting boundaries
- ACEs and attachment and intergenerational cycle (serve & return concept)
- Establishing a support network/safety plan

Session #6 – Taking care of my past

- Review approaches to dealing with painful memories
  - Prolonged exposure and cognitive reprocessing
  - EMDR
  - Expressive writing and other narrative work
- Expressive writing exercise
- Connection to values revisited
- Review new learning from program
- Post-intervention measures

Phase 3: Post-intervention Follow-up

- Individual session with SC/BHC clinician
  - Share the personalized self-care plan
  - Reinforce the learning/troubleshoot/answer questions
  - Make recommendations/referrals if needed/desired
- Booster sessions at 3 and 6 months post-treatment

Next steps...

- Conference feedback
- Build web-based online program
- Pilot program with smaller sample
- Test treatment efficacy
- Incorporate feedback from pilot
- Launch RCT and test efficacy
  - Tx as usual
  - Attention control
  - Tx (online versus group)